



LOMA LINDA UNIVERSITY  
 ADVENTIST HEALTH SCIENCES CENTER  
 Department of  
**RADIOLOGY**



**CARDIAC MEDICAL HISTORY QUESTIONNAIRE**

**YOUR PERSONAL INFORMATION:**

Today's Date: \_\_\_\_\_ (mm/dd/yyyy)      Date of birth: \_\_\_\_\_ (mm/dd/yyyy)  
 Age: \_\_\_\_\_      Gender :    Male \_\_\_ Female \_\_\_  
 Weight: \_\_\_\_\_ (pounds)      Height: \_\_\_\_\_ feet \_\_\_ inches

**NAME:** \_\_\_\_\_

**ADDRESS:**

Street \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**HOME** Phone Number with area code: \_\_\_\_\_

**WORK** Phone Number with area code: \_\_\_\_\_

**CELL** Phone Number with area code: \_\_\_\_\_

**FAX** Phone number with area code: \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**PHYSICIAN INFORMATION: (If known)**

**Your Primary Care Doctor's:**

Name: \_\_\_\_\_  
 Address:  
 Street \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

**Your Cardiologist's:**

Name: \_\_\_\_\_  
 Address:  
 Street \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

**IF YOU DO NOT UNDERSTAND A QUESTION, THEN IT PROBABLY MEANS THAT YOU DO NOT HAVE THE CONDITION**

**DO YOU HAVE KNOWN HEART DISEASE**  YES or  NO  
Please check all spaces that apply to you

**ONLY CHECK ONE**

<input type="radio"/> High blood pressure	<input type="radio"/> Chest pain on exertion	<input type="radio"/> Enlarged heart	<input type="radio"/> Coronary artery disease
<input type="radio"/> Previous heart attack Date:		<input type="radio"/> Idiopathic cardiomyopathy	<input type="radio"/> Hypertrophic cardiomyopathy
<input type="radio"/> Valvular heart disease Date diagnosed:		<input type="radio"/> Congestive heart failure	<input type="radio"/> Pericarditis
<input type="radio"/> Endocarditis	<input type="radio"/> Congenital heart disease Type:	<input type="radio"/> Previous heart surgery Type:	<input type="radio"/> Tachcardia mediated cardiomyopathy

**DO YOU HAVE DISEASE IN ARTERIES OTHER THAN THE HEART**  YES or  NO **ONLY CHECK ONE**  
Please check all spaces that apply to you.

<input type="radio"/> Renal insufficiency	<input type="radio"/> Peripheral vascular disease	<input type="radio"/> Diabetes Year diagnosed	<input type="radio"/> On Insulin
<input type="radio"/> Previous DVT (Leg or arm clots)		<input type="radio"/> Other _____	<input type="radio"/>

**RISK FACTOR DETERMINATION (Please check all spaces that apply to you.)**

<input type="radio"/> Sedentary lifestyle	<input type="radio"/> Currently smoking	<input type="radio"/> Quit smoking	<input type="radio"/> Lifetime non-smoker
<input type="radio"/> Regular exerciser How much?	<input type="radio"/> Relatives with heart attack <input type="radio"/> Immediate <input type="radio"/> Paternal <input type="radio"/> Maternal	<input type="radio"/> Relatives with coronary artery disease <input type="radio"/> Immediate <input type="radio"/> Paternal <input type="radio"/> Maternal	<input type="radio"/> High cholesterol Value (if Known)
<input type="radio"/> Overweight	<input type="radio"/> High stress levels	<input type="radio"/> Other _____	

**IF FEMALE:**

Do you still have periods?	<input type="radio"/> Yes <input type="radio"/> No	If no, what age did they stop?
Have your ovaries been removed?	<input type="radio"/> Yes <input type="radio"/> No	If yes, at what age?
Are you on hormone replacement?	<input type="radio"/> Yes <input type="radio"/> No	Age started _____ Age stopped _____

**DO YOU HAVE KNOWN ATRIAL FIBRILLATION (AF)**  YES or  NO **ONLY CHECK ONE**  
If you answered YES, please check all spaces that apply to you

Type of AF (if known) _____	<input type="radio"/> Intermittent	<input type="radio"/> Continuous	<input type="radio"/> Duration (if known) _____
Aware when you are in AF <input type="radio"/> Yes <input type="radio"/> No	Previous cardioversion? <input type="radio"/> Yes <input type="radio"/> No	Previous EP study? <input type="radio"/> Yes <input type="radio"/> No	Previous cardiac ablation? <input type="radio"/> Yes <input type="radio"/> No
Previous echocardiogram? <input type="radio"/> Yes <input type="radio"/> No	Pacemaker? <input type="radio"/> Yes <input type="radio"/> No	Type, brand and model (if known)	

**MEDICATIONS:**

Are you on cholesterol or lipid lowering medication?	<input type="radio"/> Yes <input type="radio"/> No	How long? _____
Are you on high blood pressure medication?	<input type="radio"/> Yes <input type="radio"/> No	How long? _____
Are you on daily aspirin?	<input type="radio"/> Yes <input type="radio"/> No	How long? _____

**PERTINENT MEDICATION LIST**

Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency

**RECENT CARDIAC TESTS**

Cardiac stress test in past year or scheduled?	<input type="radio"/> Yes <input type="radio"/> No	Location	Date
Cardiac catheterization in past year or scheduled?	<input type="radio"/> Yes <input type="radio"/> No	Location	Date
Cholesterol test in past year or scheduled?	<input type="radio"/> Yes <input type="radio"/> No	Location	Date

**PERTINENT SURGICAL PROCEDURES**

<input type="radio"/> Procedure:	<input type="radio"/> Date:
<input type="radio"/> Procedure:	<input type="radio"/> Date:
<input type="radio"/> Procedure:	<input type="radio"/> Date:
<input type="radio"/> Procedure:	<input type="radio"/> Date:
<input type="radio"/> Procedure:	<input type="radio"/> Date:

**CONTRAST CT / BETA BLOCKER CONTRAINDICATIONS**

History of allergies	<input type="radio"/> Seasonal/hay fever	<input type="radio"/> Shellfish	<input type="radio"/> Penicillin	<input type="radio"/> Demerol
<input type="radio"/> NO <input type="radio"/> YES >>>	<input type="radio"/> Xray dye/IV contrast	<input type="radio"/> Asthma	<input type="radio"/> Iodine	<input type="radio"/> Sulfa drugs
<b>Please check if you currently have or have had any of the following:</b>				
<input type="radio"/> Previous X-ray dye injection	<input type="radio"/> Irregular heart rate	<input type="radio"/> Heart failure	<input type="radio"/> Pacemaker	
<input type="radio"/> On chemotherapy	<input type="radio"/> Kidney Problems	<input type="radio"/> Multiple Myeloma	<input type="radio"/> Liver Disease	

**Is there any other significant medical or surgical history that you think we should know about? If so, please describe them in the space below.**

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*If you do not have room for everything, please put the information on a separate sheet*

**It is important that we have a list of current medications and the dosages, especially any anti-arrhythmics AND Coumadin dose.**

**PLEASE FILL OUT THIS QUESTIONNAIRE AND HAVE IT READY FOR REVIEW WHEN YOU COME FOR YOUR APPOINTMENT.**

**This will help expedite your appointment duration. THANK-YOU**